Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Consent for Release of Information

Date:_____

Patient Name:_____

Date of Birth:_____

I, _____, authorize the mutual exchange of information and/or medical records between Sensory Solutions and _____.

Signed:_____

Relationship to child:_____

*****By signing this release of information, I affirm that I am the parent or legal guardian of the name child and have been informed of the reason and need for this exchange of information. I understand that all information exchanged by these persons and/or agencies is confidential and will not be disclosed to any other party without the prior consent of the parent or legal guardian except as permitted by law. Information exchanged by these persons or agencies may be used for the purpose for which it was released. This information can be revoked at any time by submitting a written notice.**

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